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Bereavement Counselling in Uganda and Northern Ireland: A Comparison

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Abstract

Therapeutic interventions for bereavement in Northern Ireland and in the Sub-Saharan African country of Uganda are compared. Semi-structured interviews were conducted with Ugandan (n=18) and Northern Irish (n=20) therapists. These were thematically analysed. The findings focused on: the counselling context, the characteristics of counsellors, the characteristics of clients and counselling practices. Whilst there were many similarities in practice, core differences arose from the demands of these regions' predominately collectivist or individualist settings. Findings suggest that counselling interventions require adjustment to reflect cultural practices where there is less emphasis on an individualised ego, and where bereavement responses must concur with social norms.

Key words: bereavement, counselling, Uganda, Northern Ireland, cross-cultural

Introduction

Although death is a universal reality, responses to it are culturally determined (Parkes, Laungani & Young, 1997). However, the extent to which grief is considered to be a universal human response to loss remains subject to debate. Archer (2001) argues that grief is universal, on the grounds that it is documented in diverse settings and evidenced in the natural world. In contrast, Rosenblatt (2001) questions the commonality of grieving experiences. Adopting a social constructionist viewpoint, he suggests that grieving is not underpinned by simple developmental or biological processes. He notes that concepts of life and death differ across cultures (Rosenblatt, 1993); even within cultures, death practices are not static and homogenous, since diversity of belief can be found among cultural sub-groups. In spite of such cultural variation, however, Western forms of bereavement counselling are becoming increasingly international and there is a risk that they may be becoming integrated into other cultures in ways that are intrusive and potentially oppressive (Webb, 2007). The present study seeks to address this issue by comparing therapists' views of counselling practices in two contrasting cultural settings, one Western, namely Northern Ireland (NI), a province within the United Kingdom (UK), and one African, namely the east African country of Uganda.

Regardless of their internal cultural variation, Western and African settings can be contrasted in terms of expressed attitudes to, and experiences of, death and bereavement (Parkes, et al., 1997). For example, in Western societies, historical changes have been identified, reflecting movement from 'traditional societies', characterised by collective solidarity and support, to 'modern societies', characterised by individualism and fragmented social networks, and subsequently to 'post-modern societies', symbolising a global community in which individuals are bound, not by pre-existing social relationships, but by shared experiences (Walter, 2007). These changes are reflected in the emergence of formal bereavement

counselling, linked to increased levels of education, heightened ‘self-surveillance’ and the continued growth of professionalisation in society (Aldridge, 2012).

Meanwhile, the literature on African bereavement practices has identified death customs which promote the cohesion of the extended family, including continuity with ancestors, through the use of rituals designed to emphasise the relationship of the living with the dead (Middleton (1987[1966])). In this process, death is often explained as the fault of another person, associated with human malice (Seeley & Kajura, 1995). Individuals’ coping mechanisms are characterised by a strong spiritual component, frequently embedded within syncretistic belief systems *integrating a belief in witchcraft and traditional religions with Christianity* (Hodge, 2010). The expression of grief may be strictly controlled by collectively-enforced social norms. It is often short, intensive and prescribed (Fjermestad, Kvestad, Daniel & Lie, 2008), with emotion being avoided and repressed outside highly intensive mourning periods. However, here too, historical changes have been recognised. Throughout sub-Saharan Africa, the AIDS pandemic has altered formal and informal helping systems, eroding traditional rites around death and mourning (United Nations AIDS [UNAIDS]), 2012). Increasingly, the Western practice of counselling has been offered in response to these changes (Kilonzo & Hogan, 1999).

Bereavement Theories and Counselling Practices

To explain key features of Western counselling practice, it would be useful to commence with the work of Sigmund Freud whose theoretical conceptions of bereavement and grief work are still drawn on to this day (Granek, 2010; Hagman, 2001). Many contemporary bereavement theories and models are essentially based on the Freudian premise that grief-work is necessary in order to negotiate loss successfully (Hansson & Stroebe, 2007).

In Freud’s (1917) classic theory, mourning is understood as the forced, involuntary withdrawal of the cathexis of a loved one (the object). In response, the ego protests, denies the loss and strives to replace it with a substitute object, either real or imagined. Recovery occurs when the energy ties to the original object are severed and displaced onto new objects. Freud suggests that the mourner relinquishes the emotional ties to the lost object through a process of reality testing. This ‘grief-work’ process is assumed to be unavoidable, required if the loss is to be confronted and the initial denial of reality overcome. Here, grief-work is portrayed as an independent, universal and decontextualised process (Hagman, 2001).

Clearly, Freud’s conceptualisation of grieving has undergone transformative change in recent years. Various grief models have been developed (Bowlby, 1980; Kubler-Ross, 1969; Stroebe & Schut, 2001; Worden, 1991). Furthermore, many post-Freudian bereavement theorists have challenged the view that grief-work is universal and decontextualised, recognising societal differences in the meaning and experience of grief, and acknowledging that responses to loss vary according to the demands of particular social practices and belief systems (Doka, 1999; Klass & Walter, 2001; Neimeyer, 2001; Stroebe & Schut, 2001). However, in spite of these developments, bereavement theorists arguably continue to work with a conception of self in which Western notions of individualisation and introspection are deep-rooted, and grief-work

is understood to be necessary to negotiate loss successfully (Hansson & Stroebe, 2007). Western counsellors conceive of grieving as a psychological progression from emotional despair to potential recovery (Forte, Hill, Pazder, & Feudtner, 2004; Payne, Jarrett, Wiles & Field, 2002). Bereavement counselling practices focus on the provision of a safe space for clients to: talk about their loss; process the circumstances of the death; talk about the deceased; and, in some cases, say 'good-bye' (Payne et al., 2002). The intervention method used to facilitate this process depends in large part on the theoretical orientation of the counsellor.

For example, in Rogers' 'Client-centred' model, subsequently commonly understood as the 'Person-centred' model (Rogers, 1951, 1957, 1967), the focus is placed on clients' individual agency and capacity for acceptance, the aim being to promote their expression of emotion and enable them to gain insight into their grief (Sanders, 1999). In contrast, Cognitive Behavioural Therapy (CBT) encourages bereaved clients to develop a conscious awareness of their destructive thought patterns, and to replace negative, unhelpful beliefs with more positive and helpful ones (Meichenbaum, 1977). In CBT, therapists enable clients to identify the problems which have resulted from their loss and to set new, positive goals, as a means of adapting to the death of their loved one (Barbato & Irwin, 1992). Meanwhile, psychodynamic approaches, which are based most directly on Freudian theory, privilege the exploration of clients' past life experiences and their unconscious processes; the aim is to enable bereaved individuals to attribute the unfinished business of mourning to their therapist, temporarily releasing them from the ambivalent feelings that are preventing resolution.

Culturally Valid Counselling

However, the validity of these models for non-Western cultures has been questioned (Arulmani, 2007). Culturally sensitive counselling practices are now emerging, building on indigenous accounts of counselling (Gerstein, Heppner, Ægisdóttir, Leung, & Norsworthy, 2009; McGuiness, Alfred, Cohen, Hunt, & Robson, 2001), and the emerging body of theory and research in the field of multicultural counselling (Durie, 2007; McLeod, 2009; Sue & Sue, 2008).

Culturally valid counselling requires consideration of the client's personal and relational world, including the relationship of the individual, group and wider environment, along with underlying beliefs, such as how reality is understood and the concept of self (McLeod, 2009; Webb, 2007). Moreover, writers have identified key features of therapeutic interventions which may require adaptation, including adaptations to the counselling hour as well as patterns and style of communication, such as the management of ambiguity, self-disclosure and verbal and emotional expressiveness (Durie, 2007; Sue & Sue, 2008). In particular, the literature offers conflicting arguments regarding the relative effectiveness of theoretical models across cultures (Tseng, 1999). Counselling practice in Africa is often seen as didactic, akin to the role of the village elder who disseminates wisdom and instruction (Ugwuegbulam, Homrich, & Kadurumba, 2009). Several studies record expectations of a directive counselling approach (Oyewumi, 1986). However, other studies have found that African counsellors view

the Person-centred approach positively (McGuinness et al., 2001), a view also taken by at least one group of clients (Lie & Biswalo, 1994).

The Present Investigation

Despite this developing knowledge base, further research is still needed to advance culturally sensitive counselling practices (Arulmani, 2007), and it is hoped that the study outlined here will be of some value in this regard. In the present comparative study, counselling practices in two contrasting settings were explored in some depth. It was initiated when the first-named author (LM) who worked as a mental-health social worker and as a counsellor, transitioned from her home in NI to live and work in Uganda for a five-year period, thereby gaining experience of practicing as a ‘therapist’ in both settings.

The value of any cultural comparison depends in part upon the commonality and contrasts offered by the selected social settings. Northern Ireland has a population of 1,828,600 (Northern Ireland Statistics and Research Agency [NISRA], 2011) representing only 3% of the population of the UK as a whole. In NI, life expectancy for a man is 76 years and for a woman 80 years; infant mortality is 4.9 deaths per 1000 live births. NI is an ethnically homogenous society; over 99% of the population is white, with the next largest ethnic group (Chinese) numbering only 0.25% (NISRA, 2011). NI is perhaps best known for its 30-year history of civil conflict colloquially referred to as the ‘Troubles’. However, in 1998, most of the paramilitary groups ceased their armed struggle; sectarian murder is now rare but some sectarian violence continues. Economically, NI has a Gross Domestic Product (GDP) of £14,471 per-capita (NISRA, 2011) and is a devolved governmental region of one of the three richest commonwealth countries in the world.

In contrast, Uganda, a landlocked country in East Africa, is considered one of the world’s poorest, with a GDP per-capita of \$1000 (International Monetary Fund [IMF], 2000). Most (85%) of the population of 33.4 million live in rural communities, surviving predominantly on subsistence farming (Uganda Bureau of Statistics [UBS], 2007). In Uganda, infant mortality and life expectancy are considerably lower than in NI: its young population has a median age of 15.1 years and an infant mortality rate of 86 per 1000; life expectancy is 52 years for a male and 54 years for a female. There are currently two major influences on life expectancy. Firstly, it is estimated that 1.5 million people are living with AIDS, alongside one million AIDS orphans, with 63,000 AIDS-related deaths (UNAIDS, 2012). The second influence has been the rebel activity in northern Uganda. For 20 years, an internal war raged between the Ugandan government and the rebel group, the ‘Lord’s Resistance Army’ (LRA). Most of the estimated 75,000 people abducted during this conflict were children and young people, while the conflict also led to the emergence of a further 1.8 million internally displaced persons. More recently, a robust counter-LRA strategy has brought relative stability to the region (Otim & Wierda, 2010).

NI and Uganda cannot be regarded as uniquely distinct and homogeneous cultures situated at extreme ends of a developmental continuum, and that cultural diversity exists within these two settings as well as across them. Notwithstanding their internal diversity, the present

paper aims to focus on the two settings' dominant bereavement discourses, with the aim of looking for overarching differences between them in the ways in which death and grief counselling might be conceptualised and experienced.

Methods

This research specifically sought to explore therapists' perceptions of bereavement counselling in NI and Uganda. Its overarching research question was: 'What are the similarities and differences in the practice of bereavement counselling in Northern Ireland and Uganda, as perceived by counsellors in both settings?'

Data collection and analysis were designed to address four research sub-questions:

1. What are the similarities and differences in the context of bereavement counselling in NI and in Uganda?
2. What are the similarities and differences in the characteristics of counsellors, as represented by participants in both settings?
3. What are the similarities and differences in the bereaved individuals who seek counselling in NI and Uganda, as perceived by the participants?
4. What constitutes the practice of bereavement counselling in NI and Uganda, as perceived by the participants?

Table 1 near here

The research project commenced in 2008 and concluded in 2015, with data gathering occurring in 2008, 2009 and 2013. Participants were purposively sampled. The term 'bereavement counsellor' was broadly defined (Neimeyer, 2010). It included counsellors and professionals from a range of disciplines, such as social work and nursing, who had membership of a professional counselling body or were employed in an agency that provided bereavement counselling. Participants demographic characteristics are compared in Table 1. A total of 18 Ugandan participants were located, identified primarily through the Chair of the Ugandan Counsellors Association (UCA), who authenticated their membership of this professional organisation. They were representative of a variety of employment sectors, namely: Non-Government Organisations (NGOs), hospices, university counselling departments, corporate organisations and private practice. They included rural- and urban-based counsellors, and represented a variety of ethnic groups, including Baganda, Acholi, Lugbara, Paddola, Masaaba and Bambumbira (Lewis, Simons and Fennig, 2013), as well as three Western expatriates who had made their long-term home in Uganda. In Uganda, all but two of the participants were female, with a mean age of 45 years. In NI, participants were identified through both the Bereavement Coordinator of a Health and Social Care Trust (HSCT) and representatives of key voluntary sector bereavement agencies. In NI, a total of 20 participants were identified, only one of them male. Their mean age was 50 years. All described their ethnicity as 'white' and all were indigenous to NI. Five were employed as social workers, twelve as counsellors and one as a nurse. All offered bereavement counselling as a distinct component of their work. In both settings, participants' professional counselling

qualifications ranged from Further and Higher Education Certificates to Master's Degrees, and, in the case of two American counsellors in Uganda, also Doctoral qualifications.

Ethical approval was granted by the University of Leicester Research Ethics Committee, with additional ethical approval obtained from the relevant HSCT in NI. In Uganda, there were no organisational requirements for gaining ethical approval; however, the researcher spoke with key personnel in each counselling organisation involved in the study, outlining how she sought to promote ethical practice. In each setting, written information was given to participants prior to agreement to engage in the study. Information on confidentiality was outlined and a consent form utilised. All the counsellors contacted agreed to participate in the project. The text of all transcriptions was anonymised and files kept on a password-protected computer.

Semi-structured interviews were completed, with triangulation being promoted by the collection of additional data through desk research and participant and non-participant observations.

In total, 38 participants were interviewed. All interviews were conducted in English, the national language of both settings. Interviews were conducted either in the office of the researcher or in a location of the participant's choice. These were audio-recorded and transcribed, before being thematically analysed using a manual system based on both data-driven and theory-driven readings of the transcribed data (Braun & Clarke, 2006). The transcriptions were initially read as far as possible without reference to the research questions or any prior theoretical predictions, an inductive, bottom-up process that enabled unexpected codes to be identified, hopefully minimising researcher bias. The coding process was then repeated with an explicit theory-driven focus and the research sub-questions in mind. The theory-driven and data-driven codes were then reviewed and compared, and collated into potential themes. Typically, a major theme was identified when more than a quarter of participants discussed it; within each major theme, variations in the topic were identified and collated into minor themes. Major themes were broadly similar across settings, with greater variation noted among minor themes. To enhance the trustworthiness of the findings, in both settings, an independent researcher from the Baganda ethnic group categorised the same data. This gave rise to a jointly agreed coding structure, minimising the risk of undue Western bias.

Findings

This study's findings are now presented in relation to each of the four research sub-questions, supported where appropriate by selected participant quotations. These have been summarised in Table 2.

Table 2 about here

The Context of Bereavement Counselling

In Uganda, the AIDS pandemic prompted the arrival of international aid agencies (UNAIDS, 2012), many of which introduced the Western practice of counselling. Counselling soon

expanded to address other stress-related issues including bereavement, in part due to the large numbers of sick and dying people who overwhelmed the availability of traditional community support. In NI, bereavement counselling was first introduced through the work of voluntary organisations, the first of these being, ‘Cruse’, established in NI in 1984. Bereavement counselling subsequently expanded to include statutory sector provision as well as support offered by local community groups.

The demand for counselling in the two settings was influenced in contrasting ways by the social context. As identified in other studies (Senyonyi, Ochieng & Sells, 2012), Ugandan participants emphasised the collective nature of life, with continual declarations that people ‘belong’ to their communities:

‘There is no way that you can be whole without other people around you’ (Participant, Uganda).

Individuals’ connections to family, clan and community were pivotal. Death was integrated into day-to-day life. The community made provision for supporting its bereaved families, with strictly imposed rituals establishing the appropriate behaviour following a death. However, Uganda was also presented as a society in transition, in which communities increasingly did not have the time or resources to offer support. Participants claimed that modern ways of life were changing and, as community support declined, the need for professional interventions was becoming established:

‘Modern culture has failed its people, and is running away from its responsibilities’ (Participant, Uganda).

In contrast, participants in NI described a more individualist society in which grief was seen as unique to the individual, processed through individualised responses. They explained that families often found it difficult to support their bereaved loved ones:

‘My perception is that often families don’t know what to do to help, they don’t know how to help, it’s almost like a skill and they feel deskilled’ (Participant, NI).

The Characteristics of Bereavement Counsellors

As shown in Table 1, many of the participants’ demographic characteristics were found to be similar across the two settings. Whilst exact comparisons are difficult, the two samples appeared similar in terms of socio-economic status as indicated by estimated levels of income relative to the national average, occupational status and educational background. Similarities were also identified in their motivations for becoming counsellors and in the personal impact of this work. In both settings, participants had been trained in similar counselling models, for example, Roger’s (1957) Person-centred generic counselling model and Worden’s (1991) bereavement-focused model. However, in keeping with findings from other studies (Payne et al., 2002), eclectic approaches to counselling were commonly adopted, with theoretical rigour and conceptual purity not being high on the professional agendas of participants in either setting. Whilst counsellors in each setting tended to adopt pragmatic and eclectic approaches, Ugandan counsellors expressed differing views on the usefulness of predominately Person-

centred or directive approaches. In particular, it appeared that whilst some Ugandan participants favoured Person-centred approaches, Ugandan clients, familiar with directive approaches, might resist such interventions:

‘And actually, at times, we see somebody trying to force you to make a decision for her, which we are not supposed to do. And want to be told, go and do it this way or that way’ (Participant, Uganda).

Contrasting counselling goals were also identified. Many Ugandan participants described a dual responsibility towards the client and their communities:

‘What we intend [is] ... for this client to be in a position to support other family members go through this bereavement’ (Participant, Uganda).

In contrast, in NI, counsellors’ goals were always presented as meeting the needs of individual clients. This was often described as improving clients’ quality of life through empowerment:

‘My goal is to empower the clients to move on ... to empower all my clients, whether it is grief or whatever, to reach their full potential’ (Participant, NI).

The Characteristics of Clients

Clients in both settings were mostly women from a range of socioeconomic backgrounds. Ugandan clients were representative of different ethnic groups. In both NI and Uganda, services were offered to all individuals regardless of their religious, cultural or political beliefs. In both settings, participants identified three broad factors which impacted the help-seeking behaviour of their clients: the nature of the bereavement; interpersonal or situational factors, such as family dynamics or material resources; and intrapersonal factors, such as predisposing vulnerabilities. These are similar to a range of factors identified by other Western writers (Hansson & Stroebe, 2007). However, whilst they were broadly similar in Uganda and NI, different specific issues were highlighted in each setting.

For example, in both settings, strong family support was considered to make it much less likely that a bereaved individual would seek counselling. However, the character of this family support differed. In NI, emotional support was considered important, whilst in Uganda, the expectations, roles and responsibilities of bereaved individuals were deemed significant.

‘I was thinking about a case where the deceased person is the sole provider ... there is a wife and children and probably extended family who have been totally dependent on one person. So that grief takes another level’ (Participant, Uganda).

In Uganda, bereavement stressors were most often related to external factors, such as poverty, cultural practices disempowering women; and roles and responsibilities within the family and

community. In NI, a predominant concern of clients was that of knowing whether their grieving processes were ‘normal’. Interpersonal dynamics and the emotional aspects of the loss were also highlighted:

‘I suppose, if relationships haven’t been good with the deceased person, whoever that is, and there’s a lot of issues come up afterwards, you know, unresolved stuff, and there’s a lot of baggage from that’ (Participant, NI).

Therapeutic practices

Participants in both settings offered forms of talking therapy intended to facilitate their clients’ grief-work, however, the perceptions of their communities as either individualist or collectivist had considerable influence on this work. The usefulness of defining societies dichotomously in this way has been debated since all societies can be viewed as dynamic and diverse (Rosenblatt, 2001). However, participants clearly identified the individualist and collectivist features of their respective societies as core factors, significantly shaping their clients’ responses to death, and consequently also shaping their own counselling practices. In Uganda, counsellors offered help with financial and practical matters and also prioritised the repair of their clients’ relational networks, promoting connectedness to their communities. The focus was very much on their clients’ need to be accepted, and acceptable, within these communities. Counselling was not seen as a purely one-to-one activity, but as one always involving others, in particular, the extended family:

‘There’s a context, a big wide context, you can’t work with the individual alone’ (Participant, Uganda).

As a consequence, members of the extended family and community elders might also be present in the counselling room, for counsellors to consult:

‘I still need to consult, I can’t make my decision ... compared to the West, [where] you work with that person, they know what they want, they make their own decision’ (Participant, Uganda).

Counsellors in NI also acknowledged the interpersonal aspects of loss:

‘Always relational issues, I’ve never had a case, grief-centered or bereavement without relational issues’ (Participant, NI).

However, intrapersonal concerns were the predominant focus of their work; although relational issues might be addressed, individual clients were coached to negotiate these outside the counselling arena. One-to-one counselling was almost exclusively offered to individuals; while family members might also be offered counselling, it would probably be with a different counsellor:

‘I suppose if there were other people struggling ... I would say to them would they apply for counselling and let them see a different counsellor. Just because sometimes I think that’s better that the person I’m dealing with has that space on their own’ (Participant, NI).

In both settings, the presenting problems brought by clients included a combination of spiritual, emotional, financial, relational, physical and behavioural issues. In Uganda, unlike NI, secondary losses related to poverty were seen as the principal problem. In contrast, in NI, arguably due to the relative absence of communal grieving rituals, clients were frequently concerned to know if their grieving processes were socially acceptable:

“Am I normal?” was a big issue’ (Participant, NI).

Whilst loss was widely processed in spiritual terms in both NI and Uganda, spiritual paradigms differed. In Uganda, a collective, syncretistic belief system, which included a belief in witchcraft was identified:

‘Yes, witchcraft. Yes, in Africa most death is touched with that’ (Participant, Uganda).

In contrast, NI participants described their clients as often experiencing a personal loss of faith or anger at God.

Discussion

There is broad agreement within the counselling literature regarding normative manifestations of grief and the therapeutic approaches best utilised to support bereaved individuals. However, these are often considered to be Westernised phenomena underpinned by Western bereavement discourses (Stroebe & Schut, 1998). Practical, theoretical and philosophical aspects of Western therapeutic practices which require adjustment to suit other cultures have been highlighted (Durie, 2007; McLeod, 2009; Sue & Sue, 2008). The present comparative analysis contributes to this debate by highlighting some key differences between two diverse cultures in the ways in which bereavement counselling may be conceptualised.

Similarities and differences were identified in the counselling context. In Uganda, emphasis was placed on the collective nature of life, with the expression of grief strictly controlled by collectively-enforced social norms. In NI, participants described a more individualistic society where families often found it difficult to support their bereaved loved ones as grief was seen as unique to the individual, processed through individualised responses. These core differences, in which the individualism of NI contrasts with the collectivism of Uganda, appeared to underpin many of the other findings.

Whilst similarities were identified in counsellors’ demographic characteristics and their motivations for engaging in bereavement work, counsellor’ goals differed. There were few references to the individual re-negotiation of self by Ugandan informants, and no references to supporting the community by NI informants.

In both settings, as in other studies, the availability and quality of family support were identified as critical features which influenced help-seeking behaviour (Wimpenny et al., 2007). However, differences were found in other stress-exacerbating factors (Sue & Sue, 2008). For example, NI participants seldom mentioned the secondary losses of bereavement, whilst in Uganda, secondary losses and, in particular financial losses were commonly seen as a fundamental problem.

Finally, to a large extent, Ugandan participants offered conventional forms of Western talking therapy. This was perhaps to be expected given their training in, and use of, Western counselling models. However, as in other African studies, their counselling activities tended to be diverse (Ochieng, 2010), offering help and advice regarding financial and other practical needs. Their chosen models of intervention were often adapted in ways that reflected their own or their clients' preferences for directive or non-directive styles of communication (Sue & Sue, 2008). While some Ugandan participants favoured a non-directive, Person-centred approach, many acknowledged that their clients preferred a directive approach, as this was a more familiar communication style in their culture. Counsellors were inclined to favour such an approach, for example, by offering structured guidance to their clients in the 'right' way of doing things according to their local communities' social norms. Other African studies have also noted expectations of a directive counselling approach (Oyewumi, 1986), although the converse has also been found, with Person-centred approaches being viewed positively (McGuinness et al., 2001). Such variation in findings points to the need for caution around the development of a single cross-cultural counselling model. As with Western practices (Forte et al., 2004), the most suitable model of intervention will depend on an interplay of factors relating to client, counsellor, and counselling context (Sue & Sue, 2008).

Regardless of the specific model adopted, Ugandan participants consistently identified concerns about the underlying individualism inherent in Western counselling, in which the primary focus is an individualised self, and reflexive 'grief-work' is deemed necessary for the successful negotiation of loss. Participants in NI did not face the same difficulties in utilising these models; utilising predominately individualist models, counsellors sought to promote clients' self-actualisation, by supporting them through personal processes of meaning-making. However, arguably due to the individualised nature of grief, and the relative absence of communal grieving rituals, clients were frequently concerned to know if their grieving processes were socially acceptable, and if their grief reactions were 'normal'.

Limitations and future research

Working across settings introduced potential risks and limitations relating to bias and generalisation. We sought to moderate these risks by utilising skills of reflexivity, conceptual argument, and the systematic collection and evaluation of evidence, including the independent analysis of a sample of interview scripts, and the use of triangulation. The fact that the first author had already spent several years living and working in both countries before the formal research began helped to promote cultural equivalence.

This study adopted a broad investigative strategy since little prior research of this nature has been carried out. These broad observations should not be taken to deny the cultural diversity within NI and Uganda, and the dynamic nature of these societies.

Other potential limitations lie in the extent to which it is possible to generalise from this study's findings. The perceptions, attitudes and beliefs of 38 participants cannot be assumed

to be representative of the wider bodies of counsellors in NI and Uganda. Moreover, in-depth, detailed analyses of counsellor training and models of counselling were both outside the remit of this study. Such limitations may be addressed in future research, which would also benefit from collaboration with indigenous African counsellors and researchers (Gerstein et al., 2009). A comparative study of the relationship between traditional help-seeking activities and professional counselling in Uganda would prove insightful, along with comparative studies of counselling in different African countries, researching broadly different ethnic groups such as Bantu and Non-Bantu. Such research could contribute to the development of a matrix of counselling theories and practices which could be combined to form a model appropriate to African social contexts (Arulmani, 2007).

Conclusion

The present study generated empirical findings and theoretical conclusions which an investigation confined to a single setting would have failed to identify. Similarities across settings, in counselling modules and routines were seen as a consequence of Ugandan counsellors using imported individualistic Western counselling models. In so doing Ugandan counsellors identified contradictions between their indigenous practices and the Western bereavement counselling theory and practice. Consequently Western models were adapted to suit their society. Given this expertise in adapting Western models of counselling to their own particular cultural context, our Ugandan participants' perceptions of their work could potentially be used to inform bereavement counselling practices in other cultures.

This comparison highlighted the individualistic responses of bereavement counsellors in NI. Whilst there was a clear congruence between individualistic Western counselling models and this predominately individualistic setting, potential issues arose from the relative absence of communal grieving rituals, leaving clients concerned to know if their grieving processes were socially acceptable.

As counselling becomes increasingly international, the insights that this cultural comparison offered can be used to build on established research findings in order to develop more culturally valid, relevant and dynamic practices across settings (Arulmani, 2007).

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Table 1: Demographic characteristics of participants

Category		Northern Ireland		Uganda	
Age	Range	26-66		30-58	
	Mean	50		45	
Gender:	Female	19		16	
	Male	1		2	
Ethnicity:		Northern Irish: 9		Ugandan 15, includes ethnic groups:	
		Irish: 6		<ul style="list-style-type: none"> Acholi 1 Buganda 10 Bamfumba 1 Lugbara 1 Masaaba 1 Paddola 1 	
		British: 5		American: 2	
				British: 1	
Employment sector:		Voluntary: 8		NGO: 6	
		Statutory: 8		Private: 8	
		Independent/Private: 2		University: 2	
		Hospice: 2		Hospice: 2	
Highest Counselling Qualification	PhD	0		2	
	MA	2		6	
	BA	0		3	
	Diploma	7		3	
	Certificate	4		4	
	In-service	7		0	

Table 2: Key variations in bereavement counselling across settings

	Uganda	Northern Ireland
Context: The role played by families and communities	Local communities have made provision for supporting members.	Grief is unique to the individual; families find it difficult to offer support.
	Mourning rituals are tightly prescribed and collective.	Grief responses are largely shaped by the individual.
Bereavement counsellors: Counselling goals and models	<p>Counsellor goals:</p> <p>To engage and support communities and integrate bereaved individuals back into communities.</p> <p>Holistic approach, meeting a range of client needs including issues related to poverty.</p>	<p>Counsellor goals:</p> <p>To empower individuals to move on and to enhance their quality of life.</p> <p>Psychological approach, to help clients deal with the emotional aspects of their loss.</p>
	Key counselling models: Rogers, Worden, working eclectically.	Key counselling models: Rogers, Worden, working eclectically.
	Counsellors are directive in guiding clients.	Self-reflection is encouraged.
Client Characteristics	Family influences: Generally described in terms of roles and responsibilities.	Family influences: Generally described in terms of emotional support
	Secondary losses highlighted including poverty.	Interpersonal and emotional aspects of loss highlighted. Key concern 'Am I normal'
Therapeutic practices	Counselling sessions may include others.	Counselling sessions usually one to one.
	Relational issues core part of bereavement counselling	Relational issues dealt with outside bereavement counselling
	Meaning making informed by collective, syncretistic belief systems which includes witchcraft.	Meaning making informed by Christian belief systems, individually determined.